OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
FACILITIES DEVELOPMENT DIVISION ~ www.oshpd.state.ca.gov/fdd
1600 9th Street, Room 420 ~ Sacramento, California 95814 Phone (916) 654-3362 FAX (916) 654-2973
1831 9th Street ~ Sacramento, California 95814 Phone (916) 324-9090 FAX (916) 324-9145 North and Central Region
311 South Spring Street, Suite 1001, Los Angeles, CA 90013 Phone (213) 897-0166 FAX (213) 897-0168

Application for Incremental Project (Master)

A

Name of Facility: | Email:

Address - Street: | Phone: | FAX #:

City: | County: | Zip:

Name of Facility Representative/Administrator: | Email:

Address – Street: | Phone: | FAX#:

City: | State: | Zip:

Scope of Project (45 characters max): | Applicant Job #:

B

Description of Project: ❑ Geotech Only ❑ Preliminary

❑ **SB 1953 Mitigation Construction Project (Complete "J")**

(Please complete Section K)

C

Kind of Project: ❑ New Facility (N) ❑ Addition (A) ❑ Remodel (R)

Type of Facility: ❑ General Acute Care ❑ Skilled Nursing (SNF) and Interm. Care Facility (ICF)
❑ Psychiatric Hospital ❑ Correctional Treatment Center (CTC) ❑ Clinic

D

Legal Owner: | Phone: | FAX #: | E-mail:

Address: | City: | State: | Zip:

E

ESTIMATED COSTS

1. **Estimated construction cost of project** (Including Fixed Equipment, **excluding** Radiology Equipment, Design Fees, Inspection Fees, and Off Site work).....$ _____

2. **Estimated cost of Radiology Equipment** (X-ray, MRI, CT Scans, etc).....$ _____

FEES WILL BE BASED UPON: Skilled Nursing Facilities (SNF) are 1.5% (.015) of estimated cost
Acute Care Hospitals (Hosp) fees are 1.64% (.0164) of estimated cost
Preliminary Submittal if applicable is 10% of Total Filing Fee

F

Application for Plan Review made by (Name typed):

Signature: | Date:

Title: | Phone #:

Address: | FAX #:

City: | State: | Zip: | E-mail:

Who is to be known as: ❑ Legal Owner/Administrator
❑ Agent for the Legal Owner/Administrator (Authorization must be attached)

OFFICE USE ONLY

OSHPD #:

Facility I.D. #:

SUBMITTAL

❑ Preliminary
❑ Examination
❑ Geotech

DISTRIBUTION

❑ OSHPD
❑ Project File
❑ Rad. Health
❑ L & C
❑ _____

OSHPD RECEIPT STAMP

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Application for Incremental Project (Master)

G	Name of Facility (from front page)	OSHPD #

H Enclosed with this application are the following documents:

____	Transmittal Letter (Section 7-131)		
____	Plans	____	Geotechnical Reports (For New Facilities and Additions) Date sent: _____
____	Specifications	____	Verification of conformance to Local Codes (for New Facilities and Additions)
____	Structural Calculations	____	Project Schedule
____	Equipment Anchorage Calculations	____	_____
____	Design Program (Optional)	____	_____
____	Site Data Reports	____	_____

I **Plans and Specifications prepared by the following:** **Check discipline in general responsible charge of project** ☑

Architect – Firm: ❑

Individual Responsible:	Lic. #:	E-mail:
Alternate:	Lic. #:	E-mail:
Address:		Phone #:
City: State: Zip:		FAX #:

Structural Engineer – Firm ❑

Individual Responsible:	Lic. #:	E-mail:
Alternate:	Lic. #:	E-mail:
Address:		Phone #:
City: State: Zip:		FAX #:

Mechanical Engineer – Firm ❑

Individual Responsible:	Lic. #:	E-mail:
Alternate:	Lic. #:	E-mail:
Address:		Phone #:
City: State: Zip:		FAX #:

Electrical Engineer – Firm ❑

Individual Responsible:	Lic. #:	E-mail:
Alternate:	Lic. #:	E-mail:
Address:		Phone #:
City: State: Zip:		FAX #:

Geotechnical Report – Firm ❑

Individual Responsible:	Lic. #:	E-mail:
Alternate:	Lic. #:	E-mail:
Address:		Phone #:
City: State: Zip:		FAX #:

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Application for Incremental Project (Master)
SB 1953- Mitigation Construction Projects

J

Facility #_____
Bldg. #_____ **Bldg. Name**_____

Deficiencies Mitigated

SPC From _____ **SPC To**_____ **SPC Partial/Full**_____

NPC From _____ **NPC To**_____ **NPC Partial/Full**_____

OFFICE USE ONLY

OSHPD #:_____

_____

Region: _____

Field Review (FR) Staff:

_____

Plan Review (PR) Staff:

_____

Date: _____

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Application for Incremental Project (Master)

PROJECT SCHEDULE

K

Name of Facility: _____

Name of Building:_____ **Building #:** _____

Master Scope: _____

Master Description:

Increment #:_____

Increment Scope:_____

Increment Description:

Estimated Start Date: _____

Estimated Completion Date: _____

Critical Path: ☐ **Yes** ☐ **No** **Dependents:** _____

Increment #:_____

Increment Scope:_____

Increment Description:

Estimated Start Date: _____

Estimated Completion Date: _____

Critical Path: ☐ **Yes** ☐ **No** **Dependents:** _____

OFFICE USE ONLY

OSHPD #:_____

_____

Region:_____

Date: _____

(Please duplicate page **"K"** for more increments)

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INSTRUCTIONS FOR APPLICATION FOR INCREMENTAL PROJECT (MASTER) (OSH-FD-127)

Do not write in Office Use Only area on this application.

Note: If licensure by the California Department of Health Services is not required by your facility, review by OSHPD is not required and the application is not required. Your application and plans should be submitted to local jurisdictions.

A Enter name as it appears on the facility license. Enter email address, street address, city, county, zip code phone number and fax number.

Enter the name of the Facility Representative/Administrator, email address, phone number, fax number, city, state, and zip code. Copies of all correspondence will be sent to the Facility Representative/Administrator. If no Facility Representative/Administrator address is entered, copies of all correspondence will be sent to the Facility address as indicated on the license to the attention of Facility Administrator.

Plans returned for correction or stamping will be sent to the Architect or Engineer in general responsible charge of the project as indicated in Section I.

Scope of project - enter a brief (45 characters or less) description statement of the work to be performed. Applicant jobs number - if the facility or architect has a numbering system for projects, enter that project number.

B Description of Project - Check whether this application accompanies a preliminary or geotechnical report. Describe the work to be performed. Where appropriate, include square footage and quantities. Enter total bed count before construction and after construction.

C Check the kind of project. Check Type of Facility as licensed.

D Enter the name of the legal owner, address, phone, fax number, and e-mail address.

E Estimated Cost

Line 1. Enter estimated construction cost of project, including Fixed Equipment to be permanently attached to the building either electrically, mechanically or structurally, but excluding all design fees, inspection fees, off-site work and radiology equipment cost.

Line 2. Estimated cost of radiology equipment. (X-ray, MRI, CT Scans, etc.)

F This application for plan review is to be signed and dated by the legal owner or administrator of the facility, or agent. If signed by the agent of the legal owner or administrator, the authorization shall be attached to this application. Indicate in the

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appropriate boxes the name, signature, date, title, address, phone number, fax number, city, state, zip code, and e-mail address of the applicant.

G Enter the name of the facility from Section A on Page 1.

H Indicate the number of documents enclosed.

- Transmittal letter requesting the use of the incremental or fast track procedure.
- Plans and Specifications - Submit one (1) set of plans and specifications for projects involving the structural frame of a health facility.
- Submit one (1) set of plans and specifications for nonstructural health facility projects or for one story, type five skilled nursing facilities.
- Submit copies of structural calculations and equipment anchorage calculations.
- The applicant may submit a copy of the design program if desired.
- Site Data Reports
- Submit three (3) sets of geotechnical reports for projects involving new facilities and additions to existing facilities. If geotechnical reports were previously submitted to OSHPD, indicate the date they were sent.
- If verification of conformance to local is required, indicate that these are being included with the application.
- Project Schedule
- A space is provided for additional information or documents being enclosed with the application.

I Provide information for those disciplines which are involved in this project. Check the box for the discipline, which is in general responsible charge of this project. If plans need to be returned, they will be sent to this individual. For each discipline, provide the name of the individual in responsible charge of the project, e-mail address, his/her license number, an alternate person to contact, e-mail address, his/her license number, the address, phone and fax number, city, state, and zip code.

J Provide the following information for each building in this SB 1953 Mitigation Construction Project:

- Building name and number.
- Deficiencies mitigated by this project.
- SPC before and after construction; Partial or full Compliance.
- NPC before and after construction; Partial or full Compliance.

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Full Compliance should only be chosen if this SB 1953 Mitigation Construction Project meets all requirements for SPC/NPC compliance for the listed Building as designated in the Compliance Plan. **Incremental Projects are for 1 building only.**

K Provide the following information for the Master project:

- Name of Facility
- Name of building and building number
- Description of the Master project

Provide the following information for each increment (attach additional pages if necessary):

- Increment number (1, 2, 3, etc.)
- Increment scope
- Increment description
- Estimated start and completion dates
- Critical Path - Is completion of this increment critical to the start of another increment or must it follow another increment?
- Dependents – If Critical Path is “Yes,” indicate increment(s) to be completed prior to or following this increment.